Nevada Medicaid and Nevada Check Up Programs First Health Services Corporation LEVEL I IDENTIFICATION SCREENING (for PASRR)

PHONE: 1-800-525-2395 FAX: 1-866-480-9903

"CONFIDENTIAL"

DATE SUBMITTED to FHSC: **PLEASE TY	PE OR PRINT**
Patient Name:	SS #:
Home Address:	Medicaid Billing #: Sex:
	DOB: Pmt. Source: Marital Status:
Known Diagnoses:	Original Admit Date:Admit Date:
Legal Representative:	Admitting Facility:
Provider ID#:	Address:
Requesting Facility:	Contact Name:
Address:	Telephone:Fax:
Telephone: Fax:	Patient's Current Location HomeAcute In-PatientER
Requestor:	Acute ObservBed NF Rehab Hosp/Unit Other
SECTION I: MENTAL ILLNESS (MI) SCREENING	Concentration/task limitations within past 6 months and due to MI (exclude problems with medical basis):
1.A. Psychiatric Diagnoses	F O N Serious difficulty completing age related tasks.
Severe Anxiety/Panic Disorder Psychotic disorder	F O N Serious loss of interest in things.
Bipolar Disorder Somatoform disorder	F O N Serious difficulty maintaining concentration/attention.
Delusional Disorder Schizophrenia	F O N Numerous errors in completing tasks which he/she
Schizoaffective disorder Eating disorder (specify)	should be physically capable of accomplishing.
Major depression Personality disorder (specify)	F O N Requires assistance with tasks for which he/she should be physically capable of accomplishing.
Other:	F O N Other:
	Notes:
1.B. Psychiatric Meds Diagnosis/Purpose	3.C. Significant problems adapting to typical changes within past 6 months and due to MI (exclude problems with medical basis): Y N Requires mental health intervention due to increased symptoms.
FHSC USE ONLY: Meets diagnosis criteria for chronicity? Y N	 Y N Requires judicial intervention due to symptoms. Y N Symptoms have increased as a result of adaptation
2.A. Psychiatric treatment more intense than outpatient received in past 2 years: (MORE THAN ONCE) inpatient psych. hosp.(dates)	difficulties. Y N Serious agitation or withdrawal due to adaptation
partial hosp./day treatment(dates)	difficulties.
other(dates)	Y N Other
2.B. Intervention to prevent hospitalization: (give dates)	Notes:
supportive living due to MI(dates)	FHSC USE ONLY: MI Decision:
	FHSC USE ONLY: MI Decision: Meets criteria for disability? Meets criteria for SMI:
suicide attempt(dates)	Y N Y N
other	SECTION II: MENTAL RETARDATION (MR) AND RELATED
FHSC USE ONLY: Meets criteria for duration?	CONDITIONS (RC) SCREENING
Y N	1.A. MR diagnosis: N Y (specify)
Role limitations in past 6 months due to MI: (excluding medical problems) Indicate: "F" Frequently, "O" Occasionally, or "N" Never	B. Undiagnosed but suspected MR: N Y N/A
3. A. Interpersonal Functioning (exclude problems w/medical basis)	C. History of receipt of MR services: N Y
FON Altercations FON Social isolation/avoidance	2. Occurrence before age 18:NY
F O N Excessive irritability	(if yes, specify age):
F O N Fear of strangers F O N Easily upset/anxious F O N Suicidal talk F O N Hallucinations	Related conditions which impair intellectual functioning or adaptive behavior. Blindness Deafness
F O N Illogical comments F O N Serious communication	Cerebral Palsy Autism Epilepsy
F O N Other difficulties	Closed head injury Other
F O N Other	B. Substantial functional limitations in 3 or more of the following:
Notes:	Self-care Mobility Learning Self-direction Capability for independent living
	Understanding/use of language
	C. Was the condition manifested before age 22?
	N Y (specify) FHSC USE ONLY: Meets criteria for MR/RC?
	MR Decision: Y N

___ Date Completed: __

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STOP HERE - IF NO INDICATORS OF MI, MR OR RC	SECTION VI: OTHER CATEGORICAL DETERMINATIONS(non-limited)
OTHERWISE CONTINUE	IIFTerminal Illness: Physician has certified life expectancy of less
SECTION III: DEMENTIA (complete for both MI & MR/RC)	than 6 months. (Submit copy of certification).
A. Does the individual have a primary diagnosis of Dementia or	IIG Severe Physical Illness limited to:
Alzheimer's Disease?	Coma, Ventilator Dependence, functioning at a brain stem level
Y N (specify)	or a diagnosis of Parkinson's, Chronic Obstructive Pulmonary
B. Does the individual have any other organic disorders?	Disease, Huntington's disease, Amyotrophic lateral sclerosis
Y N (specify)	or congestive heart failure which result in a level of
C. Is there evidence of undiagnosed Dementia or other organic	impairment so severe that the individual could not be expected
mental disorders?	to benefit from specialized services.
Y N disoriented to time Y N disoriented to situation	
Y N disoriented to place Y N pervasive, significant confusion	FHSC USE ONLY:
Y N severe ST memory Y N paranoid ideation	Meets Other Categorical Determination criteria?
deficit	Y N
D. Is there evidence of affective symptoms which might be confused	SECTION VII: REQUESTING PROVIDER TO COMPLETE
with Dementia?	Mailing Information (required if indicators of MI, MR/RC):
Y N frequent tearfulness Y N severe sleep disturbance	Legal representative's name and address:
Y N frequent anxiety Y N severe appetite disturbance	
E. Can the requstor provide any corroborative information to affirm that the	
dementing condition exists and is the primary diagnosis?	
Dementia work-upThorough mental status exam	
Medical/functional history prior to onset of dementia	
Other	Primary physician's name and address:
STOP - If Dementia is primary to MI.	
CONTINUE - for all MR/RC or non-primary dementia with MI.	
FHSC USE ONLY: Meets dementia criteria?	
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SECTION IV: EXEMPTED HOSPITAL DISCHARGE (EHD)* A. Does the individual meet all of the following criteria?	Additional supporting documentation is attached/submitted.
Admission to a NF directly from a hospital after receiving	Physician's certification stating a less than 30 day nursing facility
acute in-patient care at the hospital; and	stay is needed to justify EHD is attached/submitted.
Requires NF services for the condition he/she received care in	Physician's certification for a less than six (6) month life
the hospital; and	expectancy for terminal illness is attached/submitted.
The attending physician has certified prior to NF	expectancy for terminal liniess is attached/submitted.
admission that the individual will require less than 30 days	Date Form Completed:
NF services. (Submit copy)	Name and Professional Title of Person Completing form:
* Individuals meeting all above criteria are exempt from PASRR II	
screening for 30 days. The receiving facility must submit a Level I	FHSC OFFICE USE ONLY:
by the 25th day to request PASRR Level II, when it is apparent	SUMMARY and DETERMINATION
the stay will exceed 30 days.	OUMMANT UND DETERMINATION
FHSC USE ONLY:	Has indicators of MI, MR/RC No indicators of MI,
Meets EHD criteria? Y N	MR/RC
Limitation Date:	Level I Identification Determination:
PASRR LEVEL II CATEGORICAL DETERMINATIONS	IA - Exempted Hospital Discharge
SECTION V: Time-Limited* CATEGORICAL DETERMINATIONS	IA - Qualifies for Categorical Determination
IIE. The following categories indicate the individual requires NF services	IA - Requires PASRR Level II Individual Evaluation
and does not require specialized services for the time specified.	IB - Has Dementia, Alzheimer's, Organic Brain Syndrome
A Convalescent care from an acute physical illness which	IC - Not MI, MR/RC or Demented
required hospitalization and does not meet all criteria for an EHD.	
B. Emergency protective service situation for MI or MR/RC	PASRR Level II Categorical Determination:
individual - placement in NF not to exceed 7 days.	PAS (applicant to NF) RR (resident in NF)
C Delirium precludes the ability to accurately diagnose. Facility	HE TO I WILL HAVE BY
must obtain PASRR Level II as soon as the delirium clears.	IIE - Time Limited Approval Limitation Date:
D. Respite is needed for in-home caregivers to whom the MI,	
·	IIF - Terminal Illness
MR/RC individual will return.	IIF - Terminal Illness IIG - Severe Physical Illness
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a	IIG - Severe Physical Illness
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a new Level I to request PASRR Level II ten (10) days prior to the	
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a	IIG - Severe Physical Illness Referral Needed for PASRR Level II Individual Evaluation:
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a new Level I to request PASRR Level II ten (10) days prior to the limitation date listed below for resident's whose stay is anticipated	IIG - Severe Physical Illness Referral Needed for PASRR Level II Individual Evaluation: Referred for MI Date Referred:
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a new Level I to request PASRR Level II ten (10) days prior to the limitation date listed below for resident's whose stay is anticipated to exceed that date. FHSC USE ONLY: Meets IIE Categorical Determination Criteria? A N	IIG - Severe Physical Illness Referral Needed for PASRR Level II Individual Evaluation: Referred for MI
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a new Level I to request PASRR Level II ten (10) days prior to the limitation date listed below for resident's whose stay is anticipated to exceed that date. FHSC USE ONLY: Meets IIE Categorical Determination Criteria? AYN B. Appropriate for NFYN	IIG - Severe Physical Illness Referral Needed for PASRR Level II Individual Evaluation: Referred for MI Date Referred: Referred for MR/RC Date Referred: Dual Referral MI and MR/RC Date:
MR/RC individual will return. *If any of the above are checked, receiving facility must submit a new Level I to request PASRR Level II ten (10) days prior to the limitation date listed below for resident's whose stay is anticipated to exceed that date. FHSC USE ONLY: Meets IIE Categorical Determination Criteria? A N	IIG - Severe Physical Illness Referral Needed for PASRR Level II Individual Evaluation: Referred for MI Date Referred: Referred for MR/RC Date Referred:

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